

Supervisor's Report of Incident

This is an official document to be initiated by the injured employee's Supervisor. Please answer all questions completely. Fax to your Region's EHS Manager within 24 hours of the injury. See reverse side for instructions.

Section 1: Employee (Must complete each item or processing delays will occur) - Print Clearly

| | | | |
|----------------------|----------|-------------------------|----------------|
| SCMS Claim#: _____ | | WC Location Code: _____ | |
| SCMS: (877)261-8926 | | | |
| Employee Data | | S.S. No. | Sex |
| Injured's Name | | Home Phone | Marital Status |
| Home Address | | City | State |
| Job Title | Dept No. | Office Location/Address | |
| Injury | Illness | Vehicle Injury | Near Miss |
| Hire Date | | Hourly Wage | |

Section 2: Supervisor (Must complete each item or processing delays will occur) - Print Clearly

| | | | |
|--|------------------------------------|---|------------------|
| Date of Incident | Time | Date Reported | To Whom |
| Client Name | Job Assignment at Time of Incident | | Time Shift Began |
| Exact Location & Address of Incident | | Did injured leave work? Yes No | |
| When? | | | |
| Has injured returned to work? Yes No | | Did employee miss a regularly scheduled shift? Yes No | |
| Doctor/Hospital Name | | Address of Hosp. | |
| Witness Name | | Statements Attached Yes No | |
| Nature of Injury | | Body Part | |
| Medical Treatment Received | | | |
| Describe Incident | | | |
| What caused the incident? | | | |
| Corrective Action(s) to Prevent Future Occurrence: | | | |
| Supervisor/Foreman (Print Name) | Signature | Date | Telephone |

Section 3: Manager

| | | | |
|--|-----------|------|-----------|
| Comments on incident and corrective action | | | |
| Manager (Print Name) | Signature | Date | Telephone |

Section 4: Environmental, Health and Safety

| | | | |
|--|-----------|------|-----------|
| Concur with action taken? Yes No Remarks: | | | |
| OSHA Recordable No Pending Yes - Type : Incident only First aid Medical Fatality Lost work days _____ Days of restricted activity _____ | | | |
| EHS Professional (Print Name) | Signature | Date | Telephone |

Supervisor's Report of Incident Instructions For Completion

The following types of incidents must be reported using this form:

1. Occupational Injury or Illness (includes first aid only, medical treatment, hospitalization, fatality)
2. Vehicle Accident Injuries
3. Near Miss (incident where employee(s) could have been injured)

INSTRUCTIONS

Immediate:

1. Employees must report such incidents to their Supervisor **immediately**.
2. The Supervisor must complete **Sections 1 and 2, Employee Data and the Supervisor Section** of the SRI. Incomplete items will delay timely processing. Any work-related injury or illness that requires medical treatment or care will require notifying SCMS at 877-261-8926 (Note: The WC Location Code is the employee's office's ET Office Code, preceded by the letter "C", e.g. Long Beach is C100).
3. The Supervisor must verbally notify his/her Manager, who in turn must sign **Section 3, Manager**, of the SRI. To avoid delaying SRI process, a separate copy of the SRI with the Manager's signature can be faxed within 3 days to the REHSM.
4. The Supervisor must verbally notify his/her REHSM with a follow-up SRI faxed within 24 hours (see below for fax numbers). The REHSM will review and complete **Section 4, Environmental Health and Safety**, and fax the SRI to the WCA at 804-515-8313.
5. For near-miss situations that could have resulted in an injury to an employee, the Supervisor must notify his/her Manager (see Item 3 above) and the REHSM with a follow-up SRI faxed within 24 hours.

PRIMARY CONTACTS

East REHSM: Dale Prokopchak, CIH, CSP
Telephone: 804-515-8556
Fax: 804-515-8313
Pager: 877-830-1981

WCA:
Telephone: 804-515-8557
Fax: 804-515-8313

Midwest REHSM: Jeff Grant, CIH
Telephone: 616-940-4426
Fax: 616-940-4396
Cell Phone: 734-516-5232

West REHSM: Bob Poll, CIH, CSP
Telephone: 562-951-2242
Fax: 562-495-9257
Cell Phone: 562-884-1414